DoN/HIA: Scoping

The scoping phase of the HIA process focuses on understanding the issue at hand, its complexities, and exploring the different perceptions and ideas that stakeholders might have. The present HIA approached scoping by conducting a series of key informant interviews and reviewing documentation from Community Health Initiative investments made since FY2009. We will be using emergent themes from these sources to formulate assessment methodologies, including approaches for case studies and research questions. We will continue to revisit this information in the recommendation development stage of the HIA process.

Summary of Major Themes

1. Purpose of the Program

Several themes emerged which pointed to informants' fundamental beliefs about this program. Six of these perspectives are below:

1. "This money is unique" and "this funding is extremely precious". Many of the informants expressed their belief that there is no other source of money that is as flexible. This was often expressed in the context of concerns that there would be too many changes or too many additional restrictions placed on the program.
2. "What is the unifying purpose of this money?" Several informants expressed that they do not really understand what overall principle drives the program.
3. Making the business case for prevention: it was clear through several interviews that the program could fill a gap between hospitals/health care and public health by focusing on making the financial case for primary prevention oriented activities.
4. The program needs to rest on the principle that addressing the social determinants of health is an important priority. That making this perspective more relevant to changes in health care delivery related this line of thinking to #3.
5. Investing in the community: many informants expressed their belief that the primary purpose of this money is to provide direct investment in community programs and community health (as opposed to hospital based programs).
6. While not expressed by many informants another perspective that came through strongly is that this funding should at its heart concern itself with altering power structures in institutions/organizations/communities.

2. ***Decision-Making***

One of the key questions we explored concerned decision-making dynamics. This line of questioning was summed up well by one informant who said, "money creates power dynamics". We focused this part of the interview on understanding the role of three stakeholder groups in decision-making: hospitals, community and MDPH. Emerging (and often contradicting) themes for each of these groups (as expressed by stakeholders representing each of the stakeholder groups, e.g. the points under "Hospitals" were expressed by stakeholders from Hospitals, Community groups and MDPH) are bulleted below.

A. <u>Hospitals:</u>

- Fear being seen as a blank check and they want to know more about how the funding is being used: more targeted investments, more impact reporting. The program should have structure that makes the hospitals more involved in decision-making.
- Hospitals should be collaborators, not grant makers.
- Hospitals have very different perspectives on community health. It depends on the purpose of the CHI funding in terms of how important a role they should play in making decisions.
- Hospitals have a good understanding of community health needs and how to address them through the DoN and therefore need to play a primary leadership role. Currently they are a voice in the corner.
- Hospitals should have board level approval of CHI investments/ or Hospitals should not have final say approval.
- Hospitals experience multiple "cliffs" in relation to DoN: this funding provides opportunity and risk for the hospitals that could trigger need for ongoing investment in community programs. Therefore hospitals need to be very active partners in making decision.
- Hospitals have more decision-making power behind closed doors than some may realize.
- Hospitals have control over community benefits but should not be in control of these funds.

B. <u>*Community:*</u>

Questions in this category also explored respondents understanding of what constitutes "community". Some of the more prevalent themes expressed are:

- Who is defining community? Hospitals or CHNAs or MDPH?
- How community is defined varies, and there are differing views on what is appropriate

- In the CHI context, community means the people who are most impacted by health issues
- Community is the CHNA
- There are broad differences in ways CHNAs make decisions, and the effectiveness in which those decisions are applied.
- Providers and organizations are not people in the community. This was expressed as both a negative as well as a necessity.
- It is important for CHNAs to have independence: "there needs to be a level of trust".
- It is fair for hospitals to be part of the decision-making process but the CHNA needs to have the final say.
- If you are receiving money you should not be making decisions about where the money is going.

C. *MDPH:*

We heard widely divergent beliefs about the role MDPH should have in this program and specifically on how involved the department should be in making decisions about where funding goes. This is summed up by two quotes: "This is not the department's money" and "MDPH needs to have a strong directive posture". However the most widely expressed belief is that MDPH should be a leader in essentially setting the table for investments, developing a gold standard for how to make investments and then developing a process that holds decisions to those standards.

- MDPH needs to be consistent.
- MDPH needs to be the mediator.
- MDPH needs to be more active in deciding how funds are used.
- MDPH needs to be hands-off when it comes to the final decision but provide guidance.
- MDPH's role should be on the backend of the process: accountability.
- MDPH's role should be on the front-end of the process: defining priorities.
- MDPH's role should focus on providing project management and institutional support as required by community partners
- MDPH's role should be support: providing best practices and lessons learned.
- MDPH needs a community structure in place to support local governance in some way. The principle of the current system is right because it gives people ownership over process.

3. Questions of Geography

A major issue that was discussed with informants related to where these investments are made. This part of the interviews explored themes relating not only to specific questions about

geography (e.g. a hospitals primary service area) but also on issues such as parity. For background information, hospital service areas and CHNA service areas are not always consistent. These ideas were expressed as:

- Community should be defined by the hospital service area, “won’t get a lot of buy-in unless the investments line up with the hospitals market share”. How funds have been disbursed “has not made sense” because funds have been used outside of health care service area.
- Issues of service area overlap can lead to “Incidental networking” in which a hospital’s CHI indirectly funds other hospital’s programming.
- Don’t dilute funds through some sort of redistribution until health status in primary services areas improve.
- It is critical that the CHNA gets funding, or decides how funding is used, regardless of issues of synergy with hospital service area.
- It is important to recognize the value of a hospital community health assessment but that the boundaries of the assessment should not dictate where funds are used. The opposite belief was equally or more strongly expressed, e.g. investments should line up with the boundaries of the hospitals community health assessment.
- There is a need to identify the pockets of rural and smaller cities where there is a need and where these DoN dollars don’t exist. There is a lot of regional inequality in availability of these funds. Put another way, there is a need to approach issues of geography from a parity perspective: who has needs and where resources are deficient.

4. Priority Setting:

Questions relating to how priorities for funding are selected were explored with informants. One informant summed up the complexity of this issue by saying “the heart of the question is who has the power to make decisions”. Some of the more common ideas:

- In the future there should be alignment with the State Health Improvement Plan (not the DPH strategic plan but the State goals as a whole).Otherwise there needs to be strong alignment with MDPH priorities and in areas where MDPH “has a play” (DPH should “show what works and then say this is the way” but with carrots and not sticks).
- Social determinants of health: there is a serious deficiency in funding streams that operate at this level and these funds should be used accordingly.
- The CHI program should use a Collective Impact framework
- CHI funding needs to be more intentionally aligned with community health assessments and community health improvement plans.

- Hospitals serving similar areas/regions and community groups need to work together on shared assessments and priority setting.
- Hospital programs that can be demonstrated to be successful should be eligible for these funds.

5. Defining Success:

We also asked many questions about the impact of CHI funding. As the interviews progressed we found the best way to explore this question was to simply ask how the informant would define success from a CHI investment. This led to very wide ranging perspectives.

- A very common theme was that CHI funding should have "creativity and flexibility" and measures of success should be equally flexible. One way to frame this came from an informant who said that "ROI or lack thereof is a blessing" and "can't afford to be sloppy but can afford to be creative".
- We also heard several iterations of the theme that either small mini-grants can't and won't lead to sustainable change or that mini-grants lead to innovative and creative solutions and can be the incubator of long-term change, but were often associated with higher administrative burden
- Some expressed the idea that success can be measured by the stability of organizations that provide support to broad based community health activity, and that this funding can do that.
- A selection of specific impact related observations are below:
    - Measures should focus on process, meaning developing a shared understanding of how funds are going to be used.
    - Health outcomes difficult; the unpredictable nature of the funds makes long-term impact difficult to focus on or measure.
    - Need a better shared understanding of the purpose of the CHI funding; measurement needs to be tied to the purpose.
    - Defining success is hard in public health but one area to focus on is environmental and policy changes (Mass in Motion is an example).
    - Create a shared measure as to what extent the community was meaningfully involved in the decision-making.
    - Success is meeting the needs of the community health assessment.
    - Need shared measures for both outcomes and process.

6. Cross-Cutting themes

The interviews also provided context for some cross-cutting and emergent themes that cross many of the categories above. Some of the most common related to:

Community health needs assessments and Community benefit:

- There needs to be better alignment of the multiple requirements (attorney general, local health through accreditation, state health through accreditation, DoN, CHNA, etc.).
- There is a lot of opportunity to formalize and improve the relationship between community benefits and DoN.
    - DoN is unpredictable but community benefit reporting does not have to be.
    - DoN is not equitable in its distribution and community benefits can be.
- Many however expressed concern about alignment of DoN and Community Benefit:
    - Hospitals need to control how/where their community benefits are allocated and invested so unless they would continue to exercise that power then there are concerns about how to merge DoN and community benefit reporting.
    - Accordingly, if merged the threat could be the community lacking power in decision-making.
- MDPH should create core elements that all community health assessments have to adhere to, creating the possibility of shared metrics and priorities. Currently CHAs are too different in what they look at, and how information is collected. MDPH could also coordinate locations and geographies of where CHAs are done so no region is overlooked.
- The stakeholders in one type of needs assessments are not necessarily the same as those identified to take part in the other versions. Different stakeholder can lead to different assessment objectives and findings, complicating funding streams

Other cross-cutting themes included:

- Many could envision a system where the money is spread around to areas of need from all DoNs with an expectation that there is still benefit occurring where the development is happening.
- Defining terms: what do we mean when say population health? Hospitals and public health differ. CHI/DoN is a real opportunity to get health care and public health on the same page.
- Need for more transparency and communication on how decisions are being made, for both hospitals and community partners (including CHNAs).
- Connection with local public health is a very complex issue: in some contexts the board of health agents do not understand the connection to their work, in some contexts the local health department has the capacity to provide infrastructure and guidance to these investments.

Concrete Suggestions

Many of the informants shared concrete ideas for changes to the CHI program. Some of these include:

- Committee members who make decisions about CHI funding should not receive any CHI funding.
- The Local Health Department is uniquely situated to determine how/where funds are applied and could be empowered to be the primary decision maker.
- Pool funds and equitably distribute across the state. Could create more sustainability (reduce the issue of the unpredictable nature of the funding).
- Similarly, pool funds within hospital networks to ensure smaller hospitals receive adequate CHI resources.
- Use some portion of funds to strategically invest in initiatives that align with statewide priorities
- Create an internal MDPH review board to assess consistency with whatever principles are guiding how funds are being applied.
- Hospitals could/should hire community organizers with CHI funds.
- Have hospitals create plans that are in line with their community health assessments and then have MDPH make a decision.
- The program deserves more institutional support: it is like running a foundation.
- MDPH could create a tiered system of CHNA/Hospital relationships and structures based on measurable criteria. MDPH could be more directive for the lower performing contexts and very hands-off in the high performing ones. In a system like this, pooling funds together could make sense.

Additional Feedback from the Academic Perspective (not DoN specific):

A. Questions of Geography

- Currently, there are limited incentives to push larger networked hospitals towards supporting their partnered hospital's community needs.
- CHI efforts should be clear and focused and specifically target communities/individuals/areas where unmet needs are concentrated
- Nevertheless, some successful examples exist of hospitals investing outside their primary service areas or collaborating with other hospitals

B. Priority Setting

- Hospitals can more easily justify investments that are closely related to their primary mandate of providing acute care/clinical services.
- Changes in payment environment will have a larger impact on overall hospital community investment strategies. If fee-for-service is replaced by alternative mechanisms, hospitals self-interest will better align with community needs (e.g. prevention, wellness, etc).
- Hospitals should be able to more easily collaborate on primary prevention activities, as opposed to care coordination. The existing model of providing smaller, discrete investments should be replaced with comprehensive programs which utilize these hospital partnerships.

C. Decision-Making

- Communities stakeholders involved in investment allocation should be selected not by their organizational affiliation, but by competency (expertise in community organizing, knowledge of epidemiology, etc).
- Community stakeholder's need actual access to the decision making process. Too often hospital's receive community input, then go behind closed doors and make unilateral decisions. Different models can be seen in various health systems that have established specific community investment divisions.
- Logic models should be used to guide the investment in these programs
- Collective impact models should be used to make decisions (and some successful examples/best practice guides exist)

D. Defining and Measuring Success

- There is too large a focus on traditional health outcome measures.
- Measures must be included to track program impact and increase accountability
- Measures should focus on the social determinants of health. Some examples include: absenteeism, crime, dropout rate, hospital utilization
- With respect to data, hospitals should monitor changes in utilization patterns
- Hospital and community stakeholders have should have a shared role in measurement of success. When organizations are invested, they are more likely to care about the outcome(s).